A COMPARATIVE ANALYSIS OF PSYCHOGENIC FACTORS INFLUENCING ABUSE AND RECIDIVISM OF COCAINE ADDICTED PATIENTS

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

LEONARD JACKSON

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JULY 19, 1989

ABSTRACT

SOCIAL WORK

JACKSON, LEONARD B.S.N. Florida A. & .M University

A COMPARATIVE ANALYSIS OF PSYCHOGENIC FACTORS INFLUENCING ABUSE AND RECIDIVISM OF COCAINE ADDICTED PATIENTS

ADVISOR: DR. AMOS AJO

THESIS DATED: JULY, 1989

Cocaine addicted patients in treatment for the first time were paired with cocaine addicted patients in treatment for the second, third, and fourth time to compare negative attitudes toward cocaine abuse.

A quasi-experimental research design was used in the planning of the study-to test the difference between two groups with reference to their attitudes toward cocaine abuse. The research instrument was administered to male and female in-patients of a local metropolitan hospital.

The results revealed that there was no significant statistical difference in attitudes toward cocaine abuse, addiction, and dependency. These findings may reflect that the group is characteristically similar

and have similar relations secondary to prior treatments. The findings may also reflect that the difference in negative scores found highest among the second group, as evidenced by variable six, variable fifteen and variable twenty-four, indicate that continued cocaine abuse fosters negative bio-psycho-social rewards.

TABLE OF CONTENTS

LIST OF TABLES

TABLE PAGE

...One thing is certain. Without the willing cooperation of the addicts themselves in the treatment leading to a cure, you will get nowhere.
Anna-Ma Toll (1970)

CHAPTER I

INTRODUCTION

Cocaine in the form of coca, has been used for over 1,200 years by south american indians. Following Pizarros' (spanish conquistador) conquest and destruction of the Inca civilization (a central american indian culture) in the mid-sixteenth century, cocaine was widely ignored until the nineteenth century. Through chemical processing, cocaine was isolated in 1860, it gained popularity and was supported by Sigmund Freud (the father of psychoanalysis), Carl Koeller (first to use cocaine as an anesthetic for eye surgery), and William Haldstead (first to use cocaine as a nerve block to perform surgery, (Gay et. al.,1973).

The smoking of cocaine originated in Peru during the early 1970's. The substance quickly spread to several other South American countries, eventually traveling to the United States. The South American practice involves smoking coca paste, an extract produced during the manufacture of cocaine from coca leaves.

> "Cocaine is extracted from the leaves of the coca plant which is indigenous to the eastern slopes of the Andes Mountains. In its pure form, cocaine is a fine white crystalline powder which looks like sugar and dissolves easily in water. Before it is sold to the drug user, it has been through several adulterating processes (process by which drug dealers use other substances to disguise the actual weight and appearance of cocaine) before selling it to the drug user, (i.e. epsom salt, milk sugar). The most common methods of taking cocaine are by sniffing or "snorting" it through the nostrils and by injecting it into the bloodstream (Seymour & Smith, 1987).

The substance, cocaine--known in the american drug culture by such slang names as: snow, flake, girl, coke, gold dust, the rich man's (or pimp's drug, her, corrine, heaven leaf, rock, scotty, crack, freebase, white tornado, baseball, snowflake, stardust, bernice, and lady, is reported to have two very distinct pharmacologic actions: 1) as a topical or local

anesthetic of high efficacy as well as high toxicity, and 2) as one of the most powerful central nervous system stimulants known to man (NIDA, 1986).

In America, during the period from 1880-1914, cocaine was used by American marketeers in liqueurs, wines, cigarettes and cigars, medicines and beverages. Foremost of these was Coca-Cola (introduced by Asa Chandler in 1888, Coca-Cola contained cocaine until 1903), advertized to `cure your headache' and `relieve fatigue for only five cents'. Shortly after the turn of the century cocaine snuff became popular and was used fairly largely in America for its euphoric effect. It is said that blacks in particular used the drug in the form of snuff (Chopra, 1958; Lewis, 1968).

(Williams, 1914) reported that, with many blacks in the south (area located in the southeastern portion of the United States), cocaine use had developed into an epidemic of alarming proportions, he attributed the increased crime number of wholesale killings in the south directly to these "cocaine friends" (NIDA, 1976). According to (Dale, 1902), poor blacks were not the only group using cocaine heavily, he indicated that the drug was widely used in all sectors of society.

STATEMENT OF THE PROBLEM

Today, cocaine abuse is threatening the moral fibre of our society. Abusers influenced the unconscious psychological defense that prevents the them from either realizing a problem exists or, if the problem is acknowledged, taking action to get help is one of the major problems in the treatment of substance use disorders. Relapse, or return to substance use after an apparent period of recovery is the ultimate major problem. At present, cocaine is singled out to be the most frequently ingested psychoactive substance consumed by patients admitted to Physicians & Surgeons Hospital for drug treatment and therapy. In addition, recidivism rates among patients returning to the facility for treatment and therapy is primarily secondary to cocaine abuse. Subsequently, patients who have restarted cocaine abuse, may reveal factors influencing them to use cocaine during or shortly after drug treatment therapy.

SIGNIFICANCE/PURPOSE OF THE STUDY

This study is intended to serve as an aid in devising strategies which may be instrumental in reducing recidivism rates among patients who are

addicted to cocaine by analyzing affective, behavioral, cognitive, environmental, physiological, psychological, spiritual, and interpersonal attitudinal factors involved during their treatment. By bringing into focus significant factors relative to treatment practices, methodologies may be developed which may aid in cultivating a treatment program which significantly reduces the practice of substance abuse.

CHAPTER II

REVIEW OF THE LITERATURE

Definition of Cocaine Addiction. According to (DSM-III-R, 1987), cocaine addiction is classified as a psychotic substance dependence disorder. The essential feature of this disorder is a cluster of cognitive, behavioral, physiological symptoms that indicate that the person has impaired control of psycho-active-substance use and continues use of the substance despite adverse consequences. The symptoms of the dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal. Some people with physiologic tolerance and withdrawal have the dependence syndrome as defined here.

The Diagnostic Criteria of Psychoactive Substance Dependence are based on the least three of the following:

(1) substance often taken in larger amounts or over a longer period that the person intended

(2) a great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects

(3) Frequent intoxication or withdrawal symptoms when expected to fulfill major role, obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high" intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated)

(4) Important social, occupational, or recreation al activities given up or reduced because of substance use

(5) continued substance use despite knowledge of having a persistent or recurrent social psychological, physical problem that is caused or exacerbated by type of use of the substance (e.g., keeps using cocaine despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking) (7) marked tolerance: need for markedly increased amounts of the substance i.e., at least a 50 increase) order to achieve with continued use the same effect

(8) characteristic withdrawal symptoms (9) substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

Criteria for Severity of Psychoactive Substance Dependence:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupation functioning or in usual social activities or relationships with others.

Moderate: Symptoms of functional impairment between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.,

In Partial Remission: During the past six months, either no use of the substance and no symptoms of dependence.

PROBLEMS WITH TREATMENT

Cocaine abuse is one of the most prevalent and costly problems facing our society, depleting social and human resources and causing incalculable human suffering. These problems of addiction are not limited to individuals in certain social strata but appear to affect people at all levels of society.

The search for causal factors in recidivistic behaviors have been extensive. In attempting to reduce known cases of remission, various agencies offer different treatment programs endeavoring to reduce it. At present, there is no single treatment program which boasts of a cure for addictive disorders; however, several theories and methodologies have been studied in accordance with the theories. Efforts to improve established programs which demonstrate increased reliability over extended periods has frustrated both patient and practitioner alike; consequently, agencies have relied on selective theories in administering treatment and therapies. These practices vary and are

subject to the particular expertise of the agency, the particular theory or theories employed in practice, the amount of time the client will allow him/herself in treatment and the limited ability of the client to pay for the cost of the program.

Remission, or the return to substance use after an apparent period of recovery, has served the documentation it has received in agencies, hospitals and treatment facilities. (Gorski, 1982) reported that over 60 percent of alcoholics treated in the private sector programs relapsed. (Miller and Hester, 1980) concluded from various studies that over 74 percent of 500 alcoholics treated relapsed within the first year of treatment. Another study by (Hunt, Barnett, and Branch, 1971), revealed that 65 to 70 percent of treated alcoholics and heroin addicts relapsed within one year of treatment; two thirds of these relapses occurred within the first ninety days of treatment. According to (Ross, 1989), at the time of this study, 40 percent of cocaine-addicted patients at physicians & Surgeons Hospitals relapsed during 1988.

ILLICIT USE OF COCAINE

Cocaine is used frequently by intravenous injection. Death from cocaine use per intravenous injection occurs frequently among cocaine abusers. Regular users have little knowledge of the exact quality of the cocaine they purchase or of the physiology of cocaine in the body. Often the type and quality of street cocaine gives little warning to the potential user of its ultimate effect.

The fatal dose of cocaine (that dose which causes death 100 per cent of the time) is reported to be 1.2 g. or 1,200 mg. after oral ingestion. The lethal dose (amount ingested which results in death 50 per cent of the time) of the drug is approximately 500 mg in a 150 pound man. (Eiswirth, et. al., 1972). The normal digestive processes of the stomach reduces the efficacy of cocaine digested orally thereby providing less potent efficacy as cocaine injected intravenously. It has been estimated that the human liver can detoxify one lethal dose of cocaine per hour in incremental, intravenous doses, the liver has capability to detoxify as much as 10g. of cocaine a day (Gay et. al., 1973).

The most commonly publicized method of using pure cocaine today is by the process of converting street cocaine (cocaine which is purchased illegally from illicit drug dealers) into pure cocaine freebase.

> "The process of converting street cocaine or cocaine hydrochloride into its "freebase", more purified form, involves a hazardous procedure of heating ether, lighter fluid, or similar flammable solvents. Since cocaine in normal street form is not effective when smoked, an elaborate do-it-yourself chemical process converts it to a much stronger substance called "freebase.
>
> This purified cocaine base is smoked in a water pipe or sprinkled in a tobacco or marijuana cigarette (geek joint for the user to obtain a 2-minute, sudden and intense high). The substance is rapidly absorbed by the lungs and carried to the brain in a few seconds. However, the euphoria quickly subsides into a feeling of restless irritability. The freebase post-high (period after intense cocaine intoxification) is so

> uncomfortable that cocaine smokers--in order to maintain the high--often continue smoking until they are exhausted or run out of cocaine (NIDA, 1983).

AVAILABILITY OF TOOLS

Acquiring the necessary tools and chemicals needed to make freebase are available in kits sold at head shops (stores made popular during the late 1960's and 1970's secondary to their sale of pipes and cigarette papers commonly used in providing access to smoking marijuana) and by mail from manufactures and distributors. The end product is not soluble in water. Therefore, the only way to get it in the system is through inhaling it through the lungs (smoking it).

Cocaine abuse in Atlanta, Georgia seems to be the nonnarcotic drug with the most significant increase, this being concluded not from the usual data element but rather from the increased number and seizure size of loaf cocaine arrests as reported by the news media (NIDA, 1980).

OVERVIEW OF RELATED RESEARCH

In order to determine a motivational relevance in evaluating remission, several behavior models of

relapse are utilized to demarcate a wide range of stimuli associated with circumscribing a broad range of relapse behaviors. These models include conditioned compensatory response theories (Siegal, 1983), the conditioned withdrawal relief theories (Wiker, 1965), the conditioned appetitive motivational theory (Stewart, Dewitt, & Eikelboom, 1984), and the social learning theory (e.g., Marlatt & Gordon, 1985). These models share a common focus, in understanding relapse by turning attention to these factors that antecede and follow the relapse episode itself. These theories led to the formulation of models which were based on experiments designed to test the physiologically reinforcing effects of cocaine and the secondary adverse reactions the body takes when cocaine is introduced into the system. The findings of experimentation indicated that adverse or negative reaction causes large amounts of dopamine (neurotransmitter which conducts nervous impulses from one nerve through adjoining sections of the same nerve) to be deposited into the synapse (site along the nerve where the nerve sections are closely separated). At the same time, dopaminergic cells (cells which create

dopamine) reduce their output of it. The large amounts of dopamine which would normally be recaptured and inactivated by the nervous systems remains in the synapse with the potential to conduct large volumes of electrical charges. In this manner cocaine is reinforcing to the user. However, after extended periods dopamine in the synapse is used up and replaced by the depressed dopaminergic cells, this reaction produces a negative affect.

Further, complicating successful outcomes of treatment after the use of these theories in therapy were the negative and positive states anticipated to precipitate urges to restart substance abuse and/or reduce the chances for relapse.

THE CONDITIONED WITHDRAWAL MODEL

(Wilker and Ludwig, 1965) used the conditioned withdrawal model in an attempt to research drug relapse. In their experiment, they established a theoretical framework for practicing respondent and operant conditioning responses with animals and humans. They isolated primary (psychological dependence) and secondary (physical dependence) reinforcing properties. Respectively, the pharmacological reinforcing

properties occurred both directly and indirectly, rewarding the user via central nervous systemic pleasure (unconditioned response), and by suppressing the changes incurred by drug abstinence during treatment (conditioned response). Complicating their theory, they postulated that affective states such as anxiety and dysphoria could advance a false perception to the user, of physical withdrawal, and perpetuate relapse. Cues from such cravings, influenced the learned behavior (drug seeking) with which the user unknowingly conditioned himself/herself for rewards and influenced regression to substance abuse.

THE CONDITIONED COMPENSATORY RESPONSE MODEL

The Conditioned Compensatory Response Model (Siegal, 1983) proposes that the administration of a drug constitutes a conditioning trial where the conditioned stimulus consist of cues (i.e., rituals, drug paraphernalia) accompanying drug administration, and the unconditional stimulus is proposed as the pharmacological effect of the drug (physiological, cognitive, and behavioral manifestations after drug administration). After repeated pairings (use of drug paraphernalia to use with the actual drug), the

conditioned stimulus (rituals and paraphernalia) evoke responses similar to the unconditioned response (effect after drug ingestion). However, the conditioned stimulus had little impact on the development of tolerance where the conditioned response mimic the unconditioned response. Siegal's conditioning analysis also extends their range to stimuli considered to elicit withdrawal and cravings by virtue of repeated pairing with drug effects: emotional states, especially anxiety and depression are thought to serve as potent conditional stimuli for many addicted individuals, triggering craving, withdrawal, and relapse (Niaura, et.al., 1988).

THE CONDITIONAL APPETITIVE MOTIVATIONAL MODEL

The Conditioned Appetitive Motivational Model (Stewart,et. al., 1984), attempts to explain relapse. This model posits that compulsive drug use is maintained by appetitive (strong desire or craving) motivational processes. The model was derived from observations that responding for drugs can occur in the absence of deprivation, in the absence of acute withdrawal distress, and without ever experiencing drug withdrawal. This behavior is observed in animals

(after the administration of small doses) by observing their increased work ability to obtain drugs as reinforcement. Related to this process it gives reason to believe that after periods of prolonged abstinence, strong appetitive motivational states occur in which the user experiences increased drug-related thoughts and demonstrates drug seeking behaviors.

The conditioned Appetitive motivational Model also suggests that classical conditioning occurs (a drug unknown to the user becomes after use a stimuli evoking continued use and drug seeking), additionally, this model suggest that other responses may become conditioned responses consequent to the use of a drug, as well as, the occurrence of affect states which may, in some instances, discourage drug abuse.

THE SOCIAL LEARNING MODEL

The Social Learning Model (Bandura, 1977: Marlatt & Gordan, 1980) of drug use and relapse explains that relapse begins by examining addicted individuals responses to high-risk situations: 1) acute drug withdrawal or conditioned withdrawal effects elicited by drug-related stimuli, and 2) emotional states and social and other situations perceived as stressful in

their own right independent of physical withdrawal symptoms and exposure to drug-related stimuli.

These situations, involving cognition (process including perceptions, memory and judgment) determine the probability of relapse. An example of this occurs when the individual does not believe that he is affected by the effects of drug use during his abuse history, judging that, since he is not at present using (allowing a lapse in his using practices to influence his belief that he is not a user) then, he does not determine when a high-risk situation is threatening. His inability to determine his risk status predispose him to relapse.

The Social Learning Theory also proposes that a person who does not initially believe in the (fabled) effects of substance use (person at greatest risk) may be influenced to use a substance more frequently after his initial try, especially when he does not expect his altered perceptions during drug use to seemingly, improve his cognition, perceptions, judgement and, after continued use, to relieve withdrawal symptoms. The user, after continued use, then, becomes unable to determine with a degree of certainty, his perception of

himself during periods of abstinence and during consumption. At this time, his perceptions of him/herself become negative and his ability to abstain becomes less frequent. The user again demonstrates a failure to recognize a high-risk situation when it occurred.

DEFINITIONS OF TERMS

ADDICTION The condition of being addicted (to a habit) or of being an addict; specif., the habitual use of narcotic drugs;

ANXIETY A state of being uneasy, apprehensive, or worried about what may happen; concern about a possible future event.

DEPRESSION An emotional condition of lowered and unpleasant psychophysical activity characterized by a mood of pronounced hopelessness, overwhelming feeling of inadequacy, unworthiness and guilt.

DOPAMINE A central nervous system neurotransmitter

DYSPHORIA A generalized feeling of ill-being

ENVIRONMENTAL FACTORS Cultural and social influences which impact upon the user to relapse.

PHYSIOLOGICAL FACTORS Urges or cravings in response to "cues" in the environment.

PSYCHOANALYSIS A method of investigating mental processes and of treating neuroses and some other disorders of the mind

RECIDIVISM A condition characterized by habitual or chronic relapse, or tendency to relapse

RELAPSE The recurrence of a disease after apparent improvement.

REMISSION A relatively prolonged lessening or disappearance of the symptoms of a disease (drug addiction).

SPIRITUAL FACTORS Excessive or unresolved shame or guilt, a lack of meaning in life, and internal conflicts related to religious or spiritual beliefs.

STATEMENT OF HYPOTHESIS

There is no significant difference between the attitudes of those patients who have received drug treatment and therapy for the first time secondary to the psychoactive substance abuse disorder of cocaine addiction, and, those who have (relapsed) had previous treatments and therapy, secondary to cocaine addiction, among those patients who have been subjected to voluntary treatment and therapy at Physicians and Surgeons Hospital.

CHAPTER III. METHODOLOGY

RESEARCH DESIGN

A quasi-experimental, comparative research design was used in the planning of the study. Nominal and ordinal measurement was used to determine the influence of demographic information and a comparative design was used to compare significant attitudes of two groups. The group members consisted of in-patients who were subject to cocaine abuse and cocaine addiction. The participants were selected based on criteria described in the sampling section of the thesis.

An instrument was constructed so that the attitudes of both groups, primary and secondary abusers, could be measured. The design subsequently revealed differences in attitudes of the primary group (those receiving treatment for the first time and the attitudes of the secondary group (group which experienced relapse 2-4 times) to be of no significant value.

RESEARCH SETTING

The research setting was at Physicians & Surgeons Hospital. This facility attends medical-surgical and substance abuse related illnesses. It is located in a

racially mixed community. The hospital has a detoxification unit and drug therapy unit for patients recently discharged from the detoxification unit.

Many patients continue to attend the alcohol and narcotics anonymous self-help group meetings after therapy there, others attend these meetings at other facilities.

SAMPLING

The convenience sampling technique was used in this study to select participants in this study. Patients and participants were selected from the in-patient population in treatment at the hospital. The sample consisted of eight subjects who were treated only once for cocaine abuse and addiction and an additional eight subjects who experienced several relapses after receiving therapy and treatment and, who subsequently was readmitted for treatment of cocaine abuse and addiction.

DATA COLLECTION PROCEDURES/INSTRUMENTATION

The assessment instrument, copy in appendix, was used in the collection of the data. The instrument, a self-administered questionnaire, is a modified version of attitudes of substance abusers taken from the Drug

Abuse Instrument Handbook. The responses range from strongly disagree to strongly agree.

Information was obtained on the patients background (i.e., age sex, years in treatment, residence etc.) All of the in-patients in the substance abuse unit were called together by the unit director to be ask whether they would participate in the testing. Those patients who agreed to anonymous self-disclosure were given the instrument to fill and return it to the tester. The results of the comparison were then tabulated to obtain the statistics.

The instrument in its entirety, tests the attitudes of patients who have been subjected to psychoactive substance (cocaine) abuse and treatment.

DATA ANALYSIS

The SPSSX batch system was adopted for data analysis: utilizing the T-Test to compare the significance of negative attitudes toward cocaine abuse, addiction, and dependency.

The T-Test was used for the analysis of the data. A T-score for each variable was correlated with the other to determined the mean and standard deviation and critical T-Score. The t-test was performed to

determine the significance of the scores of the two groups. The individual T-scores of the two groups reflect the negative attitudes of patients being tested toward cocaine abuse, dependency, and addiction. The patient population included those who had experienced relapse and patients who were currently being treated. Other descriptive statistics (e.g., mean, dgrees of freedom, percentages, etc) are also presented.

CHAPTER IV: PRESENTATION OF RESULTS

The instrument was administered to two groups consisting of eight participants per group. The instrument was administered according to the procedure described in the preceding chapter. The results of the analysis are presented in Table I, Table II, Table III, and Table IV. The frequency distribution of sex revealed a (56.25%) male population with an average age of (32.22) years and a (43.75%) female population with an average age of (27), a marital status of (50%) being never married, (12.50%) first marriage, (6.25%) re-married, (12.50%) separated and (18.75%) divorced. The ethnic population was (93>75%) black and (6.25%) white.

There was no significant difference found at the 0.05 reliability level when measuring the negative scores for the attitude toward cocaine test. In Table IV, if there would have been a significant difference in the t-test, the results would have demonstrated an increased negative attitude score for the second group, however, the score was statistically insignificant.

A t-test analysis showed that a significant difference does exist (variable six) between the attitudes of the two groups toward having sex with a

drug user (t=-2.87, group 1 mean=1.1250, group 2 mean=2.5000, degrees of freedom=14, and two-tailed probability=0.012), an addict being a sick person (variable twwenty-four) who is not responsible for his actions and should not be blamed (group 1 mean=1.500, group 2 mean=2.7500, and two-tailed probability=0.036), and (variable twenty-six) having sex with a partner who is using drug rather than one who is not (group 1 mean=3.7500, group 2 mean=1.8750, two-tailed probability=0.003), at the (0.05) significance level. The remaining (32) variables indicate no significant difference in the attitudes of the two groups.

CHAPTER V. SUMMARY AND CONCLUSIONS

The purposes of this study was to discern a therepeutic difference in the attitudes of two groups of in-patients which would indicate concensus. Then, determine, secondary to all theories involved, a clinical diagnosis or theory which clinicians could determine additional insight into relating to the disease of cocaine addiction, and addiction in general.

In interpreting the findings, the area for the two in-treatment groups indicating a 0.05 level of reliability, a difference was found to be of no statistical importance. The statistical difference was insignificant for the two groups. However, there was some indication that the attitudes of cocaine abuse were inclined toward higher negative values in the second in-treatment group. Hypothetically, this slight difference (approx. 0.9330 reliability) may indicate that long-term cocaine abuse, age, negative reinforcing effects after cocaine use, negative psycho-social and emotional consequences secondary to cocaine abuse, loss of self-esteem, and loss of loved ones, all may prove to influence negatives attitudes of the user to cocaine abuse.

However, the relationship to treatment modalities used in treatment in various agencies including Physicians and Surgeons Hospital (conditioned compensatory response theories (Siegal, 1983), the conditioned withdrawal relief theories (Wiker, 1965), the conditioned appetitive motivational theory (Stewart, Dewitt, & Eikelboom, 1984), and the social learning theory (e.g., Marlatt & Gordon, 1985), with the now strong orientation toward an afro-centric perspective, does not at this time reflect a significant inclination toward use of either of these models or theories as a principal or primary source for constructing a reliable treatment plan for cocaine addicted patients.

Consequently, this may be secondary to the initiation of the new program and a lack of patients to refer this instrument. Rather, it would appear that all available treatment modalities should continue to be referenced to these models in fostering treatment plans for cocaine addicted patients, as well as, to include newer models being practiced and to which I have not referenced in this study.

LIMITATIONS OF THE STUDY

The major limitation of this study was that the average age of the respondent group was not within the age range of the higher frequency of cocaine abusers. Therefore, the convenience sampling technique did include a representative sample of the age group with the highest frequency of cocaine abuse.

Another limitation was that one member of the group had a primary diagnosis of alcohol abuse which made for an indeterminate relationship to cocaine dependence. Additionally, since the program has not had the opportunity to complete treatment of the in-patients, an effect of theory in practice has yet to be identified with a response rate.

CHAPTER VI. IMPLICATIONS FOR SOCIAL WORK PRACTICE

There is statistical evidence that the Social Learning Theory offers insight into the treatment of cocaine addicted patients. Social workers should be able to draw upon their expertise from social science research of psychoanalytic theory, learning theory, field theory, social exchange theory and systems theory to formulate an effective method of analyzing, educating, and treating cocaine addicted patients.

Societal influences continue to be of major consequence to the cocaine abuser and without essential methods of evaluating crisis situations, education, and strategies of prevention and therapy, existing treatment modalities will fall short of helping many cocaine addicted people. Societal influences will continue to be a major cause motivating substance abuse in our society.

Also, cultural aspects should be considered in attempting to deliver appropriate and needed services to clients from varying cultural groups in our society (i.e. homosexuals, IV drug abusers, criminals, homeless, wealthy, children, blacks, hispanics, etc.). These groups may appear to be marginal in our society

but it is not our duty as social workers to determine an appropriate judgement for human services, but to provide adequate human services to society.

Social workers and other health professionals should continue to take further initiative in seeking solution to current health problems. Relapse is a highly common and predictable component of recovery for the majority of substance abusers, as it is documented by all treatment facilities who do folow-up on the success of their treatment programs. Often, it presents a major problem for those providing treatment services as to the adequacy of the services to which they attempt to provide. Social Workers will need to recognize and deal with the reality of relapse, not just for statistical significance, but for opportunity to research a viable alternative to addiction for the addicted person.

We should examine the attitudes and perceptions of individuals in relapse, and become more educated and skillful in our assessment when working with relapses and family members. Ultimately, we should seek a social policy which would enable us to continue to pursue the provision of human services to people who

have had the unfortunate incidence of being subjected to psychoactive substance abuse and addiction. Finally, we should direct services, in kind, which would effectively confront the disease of addiction and impact its rampant spread in our society.

BIBLIOGRAPHY

Allain, A. L., Sutker, P. B. (1988). Issues in Personality Conceptualizations of Addictive Behaviors pp. 172-181, Vol. 56, No. 2, Journal of Consulting and Clinical Psychology.

Baker, T. B., Cannon, Dale, S. (Eds.). (1988). Assessment & Treatment of Addictive Disorders New York: Praeger.

Bandura, A. (1977). Social Learning Theory. Englecliffs, NJ: Prentice-Hall.

Beatrice, Melody (1988). Codependent No more: How To Stop Controlling Others & Start Caring For Yourself. Har-Row.

Brister, Phyllis D., Brister, David M. (1987) The Vicious Circle Phenomenon: Our Battle For Self-Control-How To Win The War. New: Diadem Pub.

Cohen, Sidney, M. D. (1980, April). "Coca Paste and Freebase: New Fashions in Cocaine Use." Drug Abuse and Alcoholism Newsletter, Vol. IX, No. 3.

Eikelboom, R., & Stewart, J. (1983). Conditioning of Drug-Induced Physiological Responses. pp. 507-528. Psychological Review.

Fishman, W.M., Shuster, C. R. (1982) Cocaine Self-Administration In Humans Fed Pro.

Fishman, M. W., Schuster, C. R., Resnekov, L., Shick, J. F., Krasnegor, N. A., Fennell, M. W., Freedman, D. X. (1976). Cardiovascular and Subjective Effects of Intravenous Cocaine Administration In Humans Arch Gen Psychiatry.

Gay, G., Sheppard, C., Inaba, D., Newmeyer, J.M.(1973). Cocaine in Perspective: "Gift From The Sun God" To "The Rich Man's Drug," Drug Forum.

Gay, G. R., Sheppard, C.W., Inaba, Newmeyer, J. A. An Old Girl: Flying' Low Dyin' Slow, Blinded By Snow: Cocaine In Perspective International Journal of Addiction , Vol. 8, 1027-1042 1973.

Goldberg, S. R. (Eds.) (1973). Control of Behaior By Stimuli Associated With Drug Injections, In: Goldberg, L. and Hoffmeister, F. (Eds.) Psychic Dependence Berlin: Springer-Verlag.

Goldberg, S. R., Kelleher, R. T., Goldberg, D. M., Morse, W. H. (1975). Fixed-Ratio Responding Under Second-Order Schedules Of Food Presentation Or Cocaine Injection. J Pharmacol Exp Ther In: Fed Pro 34:1771-1776.

Goldberg, S. R., Spealman, "R. D., Kelleher, R. T.(1979). Enhancement or /Drug-Seeking Behavior by Environmental Stimuli Associated With Cocaine or Morphine Abuse Injections Neuropharmacology, 18, 1015-1017.

Hall, L., Cohn, L. (Eds.) (1986). Recoveries: True Stories By People Who Conquered Addiction & Compulsions p.224. Gurze Bks.

Hodgkinson, L. (Ed.) (1986). Addictions:What They Are, Why They Happen, How They Help. Thorsens (England), Sterling. 1986.

Henningfield, J. K., Goldberg, S. R. (1983). Control Of Behavior By Intravenous Nicotine Injections In Human Subjects. Pharmacol Biochem Behav 19:1021-1026.

Jasinkski, D. R., Assessment Of The Abuse Potentiality Of Morphine-Like Drugs (Methods Used In Man). In: Martin, W. R. (Ed.) Handbook Of Experimental Pharmacology, Vol. 4, (p.197-258). Springer-Verlag.

Jessor, R., & Jessor, S (1980). A social-psychological framework for studying drug use. In D. J. Lettieri, M. Sayers, & H. W. Pearson (Eds.),

Theories On Drug Abuse: Selected Contemporary Perspectives. Rockville, MD:National Institute On Drug Abuse.

Johanson, C. E., Schuster, C. R. Animal Models Of Drug Self-Administration. In: N. K. Mello, (Ed.)(1986). Advances In Substance Abuse, Vol. 2, Greenwich, CT., pp. 219-298, 1986. Jai Press Inc.

Katz, J. L. (1979). A comparison Of Responding Under Second-Order Schedules Of Intramuscular Cocaine Injection Or Food Presentation In Squirrel Monkeys. 32:419-431. Journal of Animal Behavior. Kelleher, R. T., Chaining And Conditioned Reinforcement In Operant Behavior: In: W. K. Honig, (Ed.)(1966) Honig, (Ed.)(1966). Areas Of Research And Application. (pp.160-212) New York: Appleton-Century Crofts.

Marlatt, G. A., & Gordan, J. R. (1985). Relapse Prevention. New York:Guiford Press.

Mello, N. K.(Ed.) (1983). Advances In Substances Abuse, Vol. 3, 1983. 59.50 . JAI PR.

--Advances In Substance Abuse. Vol. 4, 1988 JAI PR.

Miller, W. R., Heather, N. H. M., (Eds.) (1986, June). Treating Addictive Behaviors: Process OF Change. (Applied clinical Psychology Ser.) 1986. Plenum Pub.

Miller, K., (Ed.) (1987, May). An Alternative Way To Achieve Free From Alcohol & Drugs. Profile press.

Natonal Institute On Drug Abuse. (1976, May). Drugs and Crime U. S. Printing Office, Washington, D. C. .

National Institute On Drug Abuse. (1980, Jan.) Local Drug Abuse: Trends Patterns And Issues, Vol. 5, p. 1-13.

National Institute On Drug Abuse. (1982, June). Guide To Research Terminology. Issue 26, p. 22.

Peele, S. (Ed.)(1987) Visions Of Addiction: Major contemporary perspectives on `Addiction & Alcoholism', Lexington Bks.

Robin, L. (Ed.)(1988). Illustrated Handbook Of Drug Abuse Recognition & Diagnosis. Bk Med.

Seymour, R., Smith D. E. (Ed.) (1987, Jun.). The Physician's Guide To Psychoactive Drugs. Haworth Pr.

Siegal, Ronald "Coke Smoking."(1979,Feb.) New England Journal of Medicine.

Siegal, S. (1979). The Role of Conditioning in Drug Tolerance and Addiction. In J. D. Keehn (Ed.), Psychology IN Animals; Research And Treatment Implications. pp.143-168). New York:Academic Press.

Stewart, J. deWit, H., & Eikelboom, R. (1984). The Role of Unconditioned and Conditioned Drug Effects in theh Self-Administration of Opiates and Stimulants. Vol. 91, pp.251-268. Psychological Review.

Tarter, Ralph (1988). Are There Inherited Behavioral Traits That Predispose to Substance Abuse? Vol. 56, No. 2, 189-196. Journal of Consulting and Clinical Psychology.

U. S. Department of Health, Education and Welfare Public Health Service. Alcohol, Drug Abuse, and Mental Health Administration. (1986, May) Drug Abuse Instrument Handbook U. S. Government Printing Office.

Wiker, A. (1973). Dynamics of Drug Dependence. Vol. 28, pp. 611-616. Archives of Genral Psychiatry.

Leonard Jackson

1052 Faith Ave. S. E.

Atlanta, Georgia 30316

June 1, 1989

Dear Sir:

I am currently an Atlanta University graduate student pursuing a Master's Degree in Social Work, in addition, I was a student here from 9/88-3/89 working on the substance abuse unit as a student social worker in training.
Currently, I am conducting a study on "Attitudes Toward Cocaine Abuse," and soliciting your assistance in allowing me to collect information from your client population. This questionnaire allows all patients involved anonymity. If permitted to distribute this instrument I would distribute it personally.

Thank you for your time and consideration.

sincerely,

Leonard Jackson

Table 1 Frequency distribution of the sex of the respondent

VARIABLE	FREQUENCY	PERCENT
MALE	9	56.25
FEMALE	7	43.75
TOTAL	16	100.00

TABLE 3 Frequency distribution of the marital status

VARIABLE	FREQUENCY	PERCENT
NEVER MARRIED	8	50.00
FIRST MARRIAGE	2	12.00
RE-MARRIED	1	6.25
SEPARATED	2	12.50
DIVORCED	3	100.00
TOTAL	16	100.00

APPENDICES

Table 3 Mean age distribution of the respondents

VARIABLE	FREQUENCY	MEAN AGE
MALE	9	32.22
FEMALE	7	27
TOTAL	16	30.38

Table 4 Frequency distribution of the ethnic identity

VARIABLE	FREQUENCY	PERCENT
BLACK	15	93.75
WHITE	1	6.25
TOTAL	16	100.00

Table 4 T-Test score for all variables in instrument including the mean and the pooled variance estimate.

VARIABLE	GROUP	MEAN	T	DF	PROB.
1.	1	1.25	0.00	14	1.00
	2	1.25			
2.	1	1.8750	0.23	14	0.821
	2	1.7500			
3.	1	1.3750	0.00	14	1.00
4.	1	1.5000	-0.68	14	0.506
	2	1.7500			
5.	1	3.2500	0.45	14	0.662
	2	2.0000			
6.	1	1.1250	-2.87	14	0.012
	2	2.5000			
7.	1	2.2500	1.53	14	0.149
	2	1.5000			
8.	1	3.6250	1.14	14	0.273
	2	3.1250			
9.	1	3.2500	0.51	14	0.519
	2	3.0000			
10.	1	2.2500	-0.21	14	0.835
	2	2.3750			
11.	1	2.6250	0.61	14	0.554
	2	2.2500			
12.	1	2.5000	1.34	14	0.201
	2	1.7500			
13.	1	1.7500	-1.34	14	0.201
	2	2.5000			

Table 4 Continued
T-Test scores for variables in instrument

VAR	GROUP	MEAN	T	DF	PROB.
14.	1	2.2500	-0.21	14	0.835
	2	2.3750			
15.	1	1.3750	-1.26	14	0.227
	2	1.8750			
16.	1	1.7500	-0.55	14	0.590
	2	2.0000			
17.	1	2.8750	-0.74	14	0.471
	2	3.2500			
18.	1	2.6250	-2.40	14	0.081
	2	3.6250			
19.	1	3.1250	-0.27	14	0.794
	2	3.2500			
20.	1	3.1250	-0.27	14	0.794
	2	3.2500			
21.	1	3.1250	-0.27	14	0.794
	2	3.2500			
22.	1	3.5000	0.30	14	0.770
	2	3.3750			
23.	1	2.6250	-0.19	14	0.855
	2	2.7500			
24.	1	1.5000	-2.38	14	0.032
	2	2.7500			
25.	1	3.3750	1.78	14	0.097
	2	2.3750			

Table 4 continued.

T-TEST scores for variables in instrument

VARIABLE	GROUP	MEAN	T	DF	PROB.
26.	1	3.7500	3.99	14	0.001
	2	1.8750			
27.	1	3.1250	0.00	14	0.001
	2	3.1250			
28.	1	3.7500	0.80	14	0.438
	2	3.5000			
29.	1	3.0000	-1.67	14	0.118
	2	3.6250			
30.	1	3.6250	0.00	14	1.000
	2	3.6250			
31.	1	2.5000	-0.98	14	0.345
	2	3.1250			
32.	1	3.2500	0.51	14	0.619
	2	3.0000			
33.	1	3.0000	0.70	14	0.493
	2	2.6250			
34	1	3.2500	0.29	14	0.776

THIS QUESTIONNAIRE IS DESIGNED TO COLLECT USEFUL INFORMATION

PLEASE DO NOT WRITE YOUR NAME ON THE QUESTIONNAIRE

PLEASE FILL THE BLANK OPPOSITE EACH QUESTION OR MAKE A CHECK BESIDE THE QUESTIONS REQUIRING ONLY A CHECK

HOW MANY DRUG TREATMENTS HAVE YOU HAD?___

WHAT IS YOUR AGE?___

WHAT IS YOUR SEX? MALE___ FEMALE___

MARITAL STATUS:

A. NEVER MARRIED __

B. FIRST MARRIAGE __

C. RE-MARRIED __

D. SEPARATED __

E. DIVORCED __

F. WIDOWED __

G. OTHER (SPECIFY) __

ETHNIC IDENTITY OR RACE:

BLACK__

CAUCASIAN__

SPANISH AMERICAN__

ORIENTAL__

OTHER (SPECIFY)__

PRESENT RELIGIOUS PREFERENCE:

PROTESTANT_____

CATHOLIC_____

JEWISH_____

OTHER_____

AFTER SELECTING ONE OF THE THREE JOB STATUSES DESCRIBED BELOW.PLEASE WRITE THE NUMBER 0, 1, OR 2 IN THE SPACE BESIDE

EMPLOYMENT STATUS: __

UNEMPLOYED = 0

PART-TIME (LESS THAN 30 HOURS PER WEEK) = 1

FULL-TIME (30 OR MORE HOURS PER WEEK) = 2

PLEASE ENCIRCLE A LETTER PLACED BEFORE YOUR SELECTION

RESIDENCE:

A. NO REGULAR PLACE

B. ROOMING OR BOARDING HOUSE

C. HOTEL

D. APARTMENT OR SINGLE FAMILY DWELLING

E. JAIL OR PRISON

F. INSTITUTION OR HOSPITAL

G. THERAPEUTIC COMMUNITY OR OTHER RESIDENTIAL FACILITY

PLEASE CHECK YOUR ANSWER BESIDE ONE OF THE FOLLOWING SELECTIONS

FAMILY COMPOSITION:

PEOPLE NOW LIVING IN YOUR HOME:

FATHER__

MOTHER__

NUMBER OF BROTHERS__

NUMBER OF SISTERS__

OTHERS_____

EDUCATION:

WHAT IS THE LAST GRADE THAT YOU COMPLETED?

1. NO SCHOOLING__

2. ELEMENTARY SCHOOL--8TH GRADE OR LESS__

3. SOME HIGH SCHOOL__

4. HIGH SCHOOL GRADUATE OR BEYOND__

5. SOME COLLEGE__

6. COLLEGE GRADUATE OR BEYOND__

7. NOW A COLLEGE STUDENT__

8. NOW A HIGH SCHOOL STUDENT__

9. VOCATIONAL OR TECHNICAL SCHOOL

0. NO ANSWER__

QUESTIONNAIRE

DIFFERENT PEOPLE HAVE DIFFERENT MEANINGS TOWARD COCAINE ABUSE, COCAINE ADDICTION, TREATMENT AND RELAPSE. THIS SECTION IS INTENDED TO DESCRIBE YOUR FEELINGS REGARDING COCAINE. WE WOULD LIKE YOUR HONEST OPINION ON EACH OF THESE STATEMENTS. ANSWER EACH ITEM AS CAREFULLY AND ACCURATELY AS YOU CAN BY PLACING A CHECK BESIDE EACH ONE AS FOLLOWS:

1. STRONGLY AGREE

2. AGREE

3. DISAGREE

4. STRONGLY DISAGREE

1. Normal people can become addicted to cocaine. SA__A__D__SD__.

2. Many well-adjusted people become addicted to cocaine. SA__A__D__SD.

3. I feel like quitting drugs for good when I'm receiving treatment for it. SA__A__D__SD__.

4. At some time my family thought that I should be hospitalized for drug addiction. SA__A__D__SD__.

5. Homosexuality (sex relations between two men or between two women) is something a drug addict might try if he needed money. SA__A__D__SD__.

6. There should be more treatment centers for individuals addicted to drugs. SA__A__D__SD__.

7. There is nothing wrong with me (except that I use drugs). SA__A__D__SD__.

8. As long as I can have drugs, I am not interested in help to overcome my habit. SA__A__D__SD__.

9. The main thing that I dislike about drugs is that they make me aggressive and assaultive. SA__A__D__SD__.

10. If I had my own business I would consider hiring some who had once been addicted. SA__A__D__SD__.
11. All addicts are pretty much alike. SA__A__D__SD__.
12. A person who is under the influence of drugs is less likely to become violent than when he is not using drugs. SA__A__D__SD__.
13. I am in favor of a law against using drugs. SA__A__D__SD__.
14. Addicts should be forced to take psychiatric treatment until they are cured. SA__A__D__SD__.
15. The reason I came to this hospital was because drugs were ruining my life. SA__A__D__SD__.
16. Drug addiction can be inherited. SA__A__D__SD__.
17. Any addict with will power should be able to give up drugs on his own. SA__A__D__SD__.
18. I can either use drugs or leave them alone. SA__A__D__SD__.
19. It doesn't bother me to watch another addict "fix." SA__A__D__SD__.
20. A drug addict is more respectable than an alcoholic. SA__A__D__SD__.

21. An addict never does abnormal sex acts when on "crack". SA__A__D__SD_y_.

22. Cocaine means more to me than anything else. SA__A__D__SD__.

23. The average coke addict is not much of a man. SA__A__D__SD__.

24. An addict is a sick person who is not responsible for his actions and should not be blamed. SA__A__D__SD__.

25. I came to this hospital because I really want to stop the use of drugs. SA__A__D__SD__.

26. I would rather have sex with a woman who is on drugs than one who is not. SA__A__D__SD__.

27. I am in favor of making drug use legal for real addicts. SA__A__D__SD__.

28. I came to this hospital to reduce my habit so I could start again. SA__A__D__SD__.

29. Our society should be changed so that an addict can get what is due him. SA__A__D__SD__.

30. I like to see an addict who has been off drugs take his first hit. SA__A__D_SD__.

31. I wish I did not have to associate with addicts. SA__A__D__SD__.

32. The only thing wrong with drug addiction is that there is a law against it. SA__A__D__SD__.

33. If a doctor were called to see me when I was seriously ill (and I did not have a habit) I would tell him that I had been addicted to drugs and for him to be careful with what he gave me. SA__A__D__SD__.

34. The problems of drug addicts would be solved if doctors could develop a drug which relieves pain but is not habit-forming. SA__A__D__SD__.

35. Most addicts are first given drugs free by dope peddlers to get them addicted. SA__A__D__SD__.